MEDICAL HISTORY

Name: _____

Reason for today's visit: _____

List all medication allergies: _____
_____

List all medications you are taking: _____
_____

Do you have a pacemaker? Yes ___No ___ Do you take Aspirin or Blood thinners? Yes ____No___
Do you have a defibrillator? Yes____No____

Medical History

Have you ever had a disease or conditions of: Please check yes or no

	YES	NO		YES	NO
Diabetes	____	____	Emphysema	____	____
Thyroid	____	____	Asthma	____	____
Kidney	____	____	Chronic Cough	____	____
Bladder	____	____	Morning Cough	____	____
Stomach	____	____	High Blood Pressure	____	____
Bowel	____	____	Chest Pain	____	____
Heart Attack	____	____	Glaucoma	____	____
Arthritis	____	____	Irregular Heart Beat	____	____
Epilepsy	____	____	Phlebitis	____	____
Seizures / Fainting	____	____	HX Melanoma	____	____

Have you ever been exposed to **HIV (AIDS)** Yes___No___
If yes, Please indicate Diagnosis or Exposure _____
Do you have **Hepatitis**? Yes____No____
If yes, Type____ Date of diagnosis_____
Do you drink alcohol daily? Yes___No___
Have you ever had dental anesthesia? (NOVACAINE) Yes___No___

SKIN

Have you ever had skin cancer? Yes___No___
Do you have a history of any specific skin diseases? Yes___No___
Anyone in your **immediate** family ever had skin cancer Yes___No___

List any other conditions we should know about: _____
_____
List any surgical procedures you have had in the last 6 months: _____
_____
Do you smoke? Yes___No___

(Women) Are you pregnant? Yes___No___

_____ _____
PATIENT OR RESPONSIBLE PARTY SIGNATURE **DATE**